mental health **AIDS**

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Biopsychosocial Update

HIV Prevention News

About Substance Users

Robles et al. (2004) randomized 557 street-recruited injecting drug users (IDUs) from "semi-rural" areas of Puerto Rico to one of two conditions: "a six-session counseling intervention using **motivational interviewing strategies in conjunction with case management techniques**" (p. 151) or a two-session control condition based on a Centers for Disease Control and Prevention (CDC) protocol. Among the 440 participants (79%) interviewed 6 months following entry into the study, those receiving the intervention were less likely to have continued injecting whether or not they had accepted drug treatment, and were more likely to have accepted such treatment than those in the control condition. Among participants who continued to inject, those receiving the intervention were less likely to have shared needles than injectors in the control condition. With additional study, this intensive, two-facet intervention "could be another viable strategy to help arrest the HIV epidemic by preventing HIV risk behaviors, entering drug injectors in treatment, and reducing drug injection" (p. 151).

**About Men Who
Have Sex with Men**

In asking 97 men who have sex with men (MSM) in New York City about their continuing HIV-negative status, Halkitis, Zade, Shrem, and

Marmor (2004) found an association between three **nonseroconversion beliefs** – "beliefs about a strong immune system preventing seroconversion, beliefs about treatment advances reducing the possibility of seroconversion, and beliefs that becoming infected with HIV is a low probability occurrence" (p. 455) – and an increased likelihood of receptive unprotected anal intercourse (UAI) with casual partners who were HIV-negative *or of unknown status.* Because UAI with partners of unknown status represents an unacknowledged risk among some HIV-negative MSM, Halkitis and colleagues encourage clinicians to "address ... false resistance related cognitions, including the perception ... that treatment advances in and of themselves can protect against HIV infection" (p. 457) when they explore antecedents of risky sexual behavior.

What about risky sexual behavior in gay couples? Theodore, Durán, Antoni, and Fernandez (2004) examined **the relationship between emotional intimacy and UAI with a primary partner** in a sample of 78 MSM living with HIV. They found that, while seroconcordant partners were more likely to engage in UAI than serodiscordant partners, emotional intimacy (i.e., trust, closeness, open communication) between primary partners was associated with *decreases* in sexual risk within sero*concordant* relationships as

well as *increases* in sexual risk within sero*discordant* relationships. "Symbolically, men in serodiscordant relationships may try to prove their love by trusting each other with their lives. [UAI] between serodiscordant partners can represent the most intimate expression of love" (p. 329), particularly when the HIV-positive partner is also the insertive partner.

Importantly, "while intimacy may motivate risky sex among serodiscordant partners and protect against risky sex among seroconcordant positive partners, it will only do so under conditions of minimal drug use prior to sex" (p. 330). Although a minority of study participants (41%) reported drug use (with ecstasy, amyl nitrate [poppers], and gamma-hydroxybutyrate [GHB] being the drugs of choice) prior to intercourse, the authors observed that drug use appears to weaken the impact of emotional intimacy on sexual decisions made by both seroconcordant *and* serodiscordant

couples. Thus,

[a]mong seroconcordant positive partners, the ability of emotional intimacy to raise health concerns and strengthen stamina against the physical temptation not to use condoms may be weakened by the intense physical euphoria engendered by ingestion of such drugs. Among serodiscordant positive partners, the greater need to receive and sustain heightened intimacy through [UAI] may also be offset by the physical euphoria and cognitive disinhibition that accompanies such drug use. Regardless of couple serostatus or level of intimacy, drug use has a powerful influence that weakens the influence of emotional intimacy on sexual decision-making. (p. 330)

Even as the authors note that "factors beyond intimacy, drug use, and couple serostatus influence sexual decision-making among HIV-positive MSM in primary relationships" (p. 330), they contend that clinicians should incorporate relationship factors into interventions and "work ... to create a new paradigm equating intimacy with a desire to preserve and protect one's partner's health" (p. 330).

Kalichman, Gore-Felton, Benotsch, Cage, and Rompa (2004) surveyed a convenience sample of 647 MSM attending a major gay pride event. They found that men who reported a history of childhood sexual abuse, in comparison with those who did not, were more likely to engage in receptive UAI; trade sex for drugs or money; use tobacco products, crack cocaine, and/or methamphetamine; experience relationship violence in adulthood; and self-identify as HIV-positive. These men also experienced more **borderline personality symptoms**. Kalichman and colleagues observe that

[o]ne important residual effect of childhood sexual abuse ... may be difficulties ... in interpersonal relationships as suggested by borderline personality symptoms. ... [B]orderline ... symptoms may result in these men experiencing difficulty with interpersonal boundaries, impulsivity, and distorted social perceptions. ... [Importantly, a]lthough borderline personality symptoms were related to child sexual abuse history [in this study, the authors] did not find that borderline symptoms were associated with high-risk sexual behavior after controlling for substance use and childhood sexual abuse. (p. 12)

With regard to HIV risk reduction interventions for MSM who report a history of childhood sexual abuse, the authors recommend that interventions should "address the long-term effects of ... abuse on social perceptions, sexual decisions, and sexual relationships. ... [I]nterventions delivered at the individual level through counseling and small group workshops offer opportunities for addressing issues of mental health and emotional adjustment that can impede individual choices for self-protective actions" (pp. 12-13).

Utilizing audio computer-assisted self-interviewing (ACASI) questionnaires with 387 drug-using MSM who were largely African-American, Newman, Rhodes, and Weiss (2004) found that **sex trading** was associated with use of crack cocaine, use of injection drugs, childhood maltreatment, not self-identifying as gay, and homelessness. In considering these risk factors, the authors observe that

the majority of HIV prevention programs, which rely on social-cognitive, individual, or small-group models, may be inadequate for addressing high-risk behaviors among MSM who trade sex. Interventions for MSM who trade sex may need to target drug dependence and economic hardship to prevent HIV infection risk behaviors. In addition, programs that are overtly identified as gay (e.g., housed in gay service organizations) may be unlikely to reach the high proportion of MSM who trade sex but do not self-identify as gay. Our largely African American sample of MSM also suggests that we may need to overcome the frequent stereotypification of high-risk, drug-using MSM as European American methamphetamine users to facilitate innovations in targeting HIV prevention interventions for men who engage in sex trading. (p. 2002)

About Women
Wenzel et al. (2004) conducted structured interviews with two strati-

fied random samples of women – 460 women residing in shelters and 438 women residing in low-income housing – in Los Angeles County. Even when controlling for demographics, they found that sheltered women, in comparison with housed women, were more likely to report experiences of physical and sexual violence, HIV risk behavior, substance use and disorder, and the co-occurrence of these problems over the preceding year. On the basis of these findings, Wenzel and colleagues encourage clinicians to differentiate among subgroups of **indigent women** in the planning of interventions.

The significantly higher rates of health threats among women living in shelter situations suggest that these women urgently need services to simultaneously enhance their HIV protective behaviors, reduce their alcohol and drug use, reduce their risk of being victimized, and address any negative physical or psychological impacts of having been previously victimized. For women entering shelters, screening and assessment for violent experiences and substance use could be instituted, and screening must be followed by appropriate referrals to services and safeguards against excluding women from eligibility for shelter services in the case of positive screens. Ideally, appropriate services would be provided to women in-house, ... [since t]he group setting of the shelter may facilitate the more intensive services that women in these settings need ... and is an ideal one for instructional activities in HIV risk reduction as well as education on the co-occurrence of HIV risk, violence, and substance use. (p. 622)

Harvey and Bird (2004) focused on **the connection between power in**

heterosexual relationships and sexual decision-making through exploratory interviews involving two samples: 22 young, African-American women at risk for HIV/sexually transmitted diseases (STDs) and their male partners; and an additional 40 young, African-American women at risk for HIV/STDs without their partners. As for what makes women feel powerful in their relationships with a husband or partner, four themes were identified: 1) the link between relationship power and having control/making unilateral decisions; 2) power derived from money, education, and/or physical attractiveness; 3) power derived from feeling nurtured/cared for by one's partner; and 4) sharing sexual decision-making – and thus sharing power – with one's partner. Harvey and Bird go on to observe that

[c]ultural beliefs about women's feelings of power in relationships could be addressed in the design of interventions ... intended to reduce HIV/STD transmission among young African American women. For example, if women believe that having goals, making decisions for themselves, and being able to provide for their families are important sources of power, then providing access to job and skills training and professional development may enhance women's feelings of power and, in turn, support ... prevention behaviors. Similarly, given that having strong, secure relationships with their partners is believed to be an important source of ... power, and that many women appear to make sexual decisions jointly with their partners, then building and strengthening ... relationships could prove to be an important strategy for disease prevention. (p. 17)

About Women & Men
Harvey et al. (2004) continued the

relationship focus by randomizing 146 young Hispanic couples – primarily of Mexican descent – to one of two intervention conditions: a three-session **culture-specific, couple-based risk reduction intervention** or a single session focusing on pregnancy and STD prevention. After 3 months, *both* groups reported reductions in unprotected vaginal intercourse and increased use of condoms and other contraceptive methods. "If further research confirms that simply bringing couples together for a single-session, culturally appropriate risk reduction intervention helps them adopt protective behaviors," reason the authors, then "more intensive (and costly) interventions may not be necessary" (p. 162).

Noar, Morokoff, and Harlow (2004) explored **condom influence strategies** (CISs) employed by an ethnically diverse convenience sample of 113 heterosexually active men and women at risk for HIV. They found that these individuals "use a variety of influence strategies (withholding sex, direct request, seduction, relationship conceptualizing, risk information, deception, and pregnancy prevention) when attempting to procure condom use with a sexual partner" (p. 1743) and that use of these strategies is associated with use of condoms. Notably, study participants at highest risk for contracting HIV were also less likely to use both CISs and condoms, while those endorsing CISs were also more likely to feel confident that they were capable of persuading their partners to utilize condoms. Two important implications for intervention emerge from these findings:

First, individuals may not benefit from skills-focused interventions if they are not convinced that they need to engage in the behavior (e.g., condom use) in the first place. ... As individuals'

readiness to use condoms consistently increases, so does their motivation to use CISs with their sexual partners. Thus, interventions must first aid these individuals in an awareness of their risk before teaching them skills they may not use.

Second, interventions need to not only teach behavioral skills (e.g., condom influence and negotiation), but must also increase self-efficacy to carry out those skills. If individuals possess skills but have no confidence (self-efficacy) that they can successfully use those skills, then it is unlikely that they will put those skills to work ... . Further, as relapsing to unsafe sex is frequent in high HIV risk populations ..., even those who have begun to use condoms consistently may need continued support and intervention. (pp. 1746-1747)

Albarracín, Kumkale, and Johnson (2004) conducted **a meta-analysis** of 129 data sets **to examine condom use behavior**. Their analysis included both published *and* unpublished data sets available by June 2000 and descriptive of 30,270 participants. They found that members of groups lacking in social power (e.g., younger individuals, women, ethnic minority individuals, those with lower educational levels) had greater intentions toward use and were more inclined to use condoms when they believed that they could use them if they wanted to (i.e., they perceived that they had behavioral control over their use of condoms) in comparisons with people with greater social power. They also found that social norms (i.e., perceiving that one's social network supports condom use) affected condom use more strongly among younger persons, as well as those with greater access to advice from their social network on this topic

(e.g., men, ethnic majority individuals, and those with higher educational levels) in comparisons with older persons and those with less access to such advice.

What do these findings suggest about prevention interventions?

The meta-analysis ... suggests that different preventive programmes may be necessary depending on whether the target recipients are older or younger, male or female, an ethnic majority or minority, educated or illiterate. Perceived behavioural control and norms influence actual condom use more when power and normative support are scarce than when they are plentiful. ... [Therefore], if interventions can only change the level of actual attitudes, norms or perceived behavioural control, then the intervention messages should target the factor that is most influential in a given population ... . Alternatively, interventions may attempt to influence the weight of attitudes, norms or perceived behavioural control, or even make structural changes to increase social resources or strengthen informational support for a given social group. (p. 717)

In other words, this review suggests, that interventions designed to increase perceptions of personal control (e.g., behavioral skills interventions) as well as empowerment approaches "are likely to be more effective for younger, female, ethnic minority and less-educated recipients than for older, male, ethnic majority and more educated individuals, because control perceptions have stronger effects in the former groups" (p. 717). At the same time, interventions that are "designed to promote more positive subjective norms concerning condom use may be more effective for younger, male, more educated and

ethnic majority individuals among whom norms are more influential than attitudes" (p. 717).

What prevention messages address the concerns of transgenders? To find out, Nemoto, Operario, Keatley, and Villegas (2004) conducted focus groups with 48 African-American, Latina, and Asian and Pacific Islander **male-to-female** (MTF) **transgenders** at risk for HIV who were living and/or working in San Francisco.

Participants were likely to report having unprotected sex with primary partners to signify love and emotional connection, as well as to receive gender validation from their partners. In contrast, viewing sex work with customers as a business encouraged intentions to use condoms. Safer sex intentions with customers were frequently undermined by urgent financial needs, which stemmed from transphobia, employment discrimination and costly procedures associated with gender transition. Participants reported using drugs as a way to cope with or escape life stresses associated with relationships, sex work, transphobia and financial hardship. (p. 724)

These findings suggest that interventions with MTF transgenders at risk for HIV

should address the social context of risk behaviours, particularly relationship and sex work issues related to gender validation, transphobia and drug use. ... [S]ervices should help MTF transgenders reevaluate norms for intimate relationships – for example, their motives for entering into relationships and how they express affection and set boundaries with primary partners without lowering their power for negotiation. ... Clearly, it is

[also] important to educate both transgendered individuals and their partners about the prevalence of HIV in the transgender community, as well as the potential for HIV infection within the context of a primary relationship. (p. 734)

Finally, in a sample of 333 HIV-positive people engaged in medical care, Kozal et al. (2004) found that 23% had unprotected sex in the preceding 3-month period, representing 1,126 unprotected events with 191 different partners, 155 of whom were thought to be either HIV-negative or of unknown status. When risk behavior data were linked to data on HIV drug resistance, 24% of those engaging in unprotected sex did so while harboring **drug-resistant strains of HIV**. While these individuals represented about 5% of the entire study population, they "accounted for a large number of high-risk HIV transmission events with resistant virus, exposing a substantial number of partners" (p. 2185). "Of those variables that might differentiate antiretroviral-resistant patients engaging in risk behavior from resistant patients who are not, mental health functioning appears critical, and addressing mental health issues may be the key to reducing transmission risk behaviors" (pp. 2188-2189).

From the Block
Center for Comprehensive Care

The Center for Comprehensive Care (CCC) at St. Luke's-Roosevelt Hospital Center was established in 1986 and designated a New York State AIDS Center in 1987. As such, the CCC offers a continuum of services to persons living with HIV and AIDS. Today the CCC is one of the largest providers of HIV/AIDS health care and support services in New York State, serving more than 3,000 persons annually.

Having removed access barriers through the delivery of comprehensive services, CMHS/SAMHSA funding is being used to enhance programmatic structure through the development of services that did not exist or existed on a smaller scale prior to funding. The overarching goal for this project is to reduce racial and ethnic disparities in mental health referral and retention.

Clinical services include primary care mental health screening and referral, social work evaluation, mental health assessment, individual and/or couples/family counseling, group therapy, psychopharmacology, case management and referral, and three new programs:

  o Patient engagement groups, designed to increase knowledge about "the range of problems for which someone might seek mental health care, the difference between psychiatry and psychology, what to expect at an initial mental health evaluation, symptoms of common mental disorders, and psychological side effects of HIV medications";

  o *The Parenting Journey,* an intensive 12-week workshop in which parents come to understand the influences of their own personal histories on their roles as parents, developed by the Family Center in Somerville, Massachusetts; and

  o Mindfulness-Based Stress Reduction (MBSR) training, modeled on the clinically proven program developed by Jon Kabat-Zinn, PhD at the University of Massachusetts Medical Center.

The Principal Investigator/Clinical Director is Hannah Wolfe, PhD; the Co-Principal Investigator is Victoria Sharp, MD; the Project Director is Christine Nollen, MPH, MPA. For more information, please call 212/523-6500 or go to: http://www.centerforcare.org/index.html.

– Compiled by the MHHSC Program Coordinating Center

HIV Assessment News
HIV Counseling & Testing
From a survey involving 558 community-recruited, **active IDUs**, Tobin, Tang, Gilbert, and Latkin (2004) report that "factors independently associated with having been tested recently [(i.e., within the preceding 12-month period)] tended to reflect the strong influence of external factors such as being incarcerated, and resources such as having interactions with an HIV prevention outreach worker or having a case manager" (p. 307). Additionally, recent testing of an IDU's main sex partner was positively associated with having received recent HIV testing. Tobin and colleagues conclude that "[s]upport of programs that are designed to serve hard-to-reach populations and target couples may be effective in increasing HIV testing among active IDUs" (p. 303).

In an exploratory study, Bonney, Crosby, and Odenat (2004) interviewed a convenience sample of 143 low-income, largely African-American women with a history of HIV testing and found that "perceived barriers and supportive factors play equally important roles in **women's intent to be repeat tested for HIV**" (p. 333).

Frequently perceived barriers included perceptions that repeat testing was unnecessary, either based on: 1) having only one sex partner since the last test (38.1% of responders); 2) obtaining a negative test result in the past year (36.7%); 3) worry about coping with a positive diagnosis (30.7%); 4) a belief that "guys I have sex with always use condoms" (27.5%); or 5) a belief that treatment may not be affordable (25.2%). ... A broad range of supportive factors were endorsed, including: 1) testing is part of self-care (85.8%); 2) knowing to avoid sex if HIV-posi-

For many, the decision to provide clinical care to people living with HIV and AIDS constitutes an intellectually rich and emotionally satisfying career choice. And yet, even in the era of highly active antiretroviral therapy (HAART), which has extended survival and engendered the hope of converting HIV to a chronic but manageable disease for all who are infected, work in this field is fraught with multiple stressors that may induce provider burnout.

Does This Sound Like You?
[B]urnout syndrome has been most consistently described as a multi-dimensional process with 3 central constructs: emotional exhaustion (feeling emotionally drained and exhausted by one's work), depersonalization (negative or very detached feelings toward clients ...), and reduced personal accomplishment (evaluating oneself negatively

and feeling unsatisfied with positive job performance and achievements). ... The most fundamental tenet of burnout syndrome is that it is an end-stage consequence of a process of deterioration in a person who has been exposed to relentless stress in the work environment. (Demmer, 2004, p. 523)

It is no surprise, then, that "[b]urnout has been related consistently and negatively to health, work performance, job satisfaction, quality of life and psychological well-being" (Rabin, Feldman, & Kaplan, 1999, p. 160).

Who is at risk for burnout? According to Demmer, a variety of factors are associated with a greater likelihood of burnout in providers of HIV care. These include "younger" age (with burnout perhaps related to a lack of HIV work experience and/or overinvolvement with clients); anxiety and/or depression; low "hardiness" levels (i.e., feeling and acting alienated, helpless, and insecure); a high external locus of control (i.e., believing that events occur as a result

of fate, luck, or chance); external coping strategies (i.e., denying, avoiding, or passively accepting work-related stressors); fear of contagion; negative attitudes toward clients (due to work role dissatisfaction and/or work overload); the perception that HIV work is difficult; problematic relationships with colleagues, supervisors, or higher-level administrators; and inadequate support from friends and family around the choice to work in the HIV field.

From the HAART
During "the dark years" of the pandemic (up to the mid-1990s), many health care workers experienced demoralization, despair, and frustration as they cared for their patients. ... Research identified the following stressors of HIV/AIDS caregiving during the years before the advent of HAART: the clinical manifestation of HIV/AIDS and the course of the illness, ... risk of contagion, ... high mortality rate among patients, ... dealing with such issues as homosexuality and drug addiction, ... ethical concerns about con-

tive (85.8%); 3) test results are reliable and important (84.7%); 4) early diagnosis can improve odds of staying healthy (83.0%); and 5) coping with a positive test result, and paying for treatment, would be manageable (78.6% and 78.2%, respectively). (p. 330)

The authors suggest that "favorable decisional balance may be achieved by helping women overcome key barriers to repeat testing, while also making multiple factors supporting repeat testing more salient to women" (p. 333).

Psychiatric Assessment
British investigators (Cove & Petrak, 2004) surveyed 78 gay men receiving HIV-related medical services and found that about two-thirds reported one or more **sexual dysfunctions** (SDs). More specifically, 41% reported loss of sexual desire, 24% reported delayed ejaculation, and 38% reported erectile dysfunc-

tion (ED). ED increased to 51% when condom use was attempted and was associated with inconsistent condom use by the insertive partner during anal sex, being the receptive partner during anal sex, and risk cognitions (e.g., "condoms interfere with pleasure"; "I want to lose myself in sex"). Cove and Petrak also found that

[g]ay men attribute [their SDs to] a variety of causes according to the type of problem and in particular report high levels of perceived psychological causation [of ED associated with condom use]. These factors, together with patients' physical and general mental health status, indicate the multi-factorial aetiology of sexual difficulties and thus the need for thorough psychological as well as physiological assessment and intervention. Untreated sexual difficulties may contribute to risk taking in sex as some seropositive gay men

attempt to bolster impaired sexual arousal by avoiding use of condoms or taking the receptive role in anal sex. ... [B]oth [sexual problems and risk taking in sex] need to be addressed in order to improve sexual fulfilment of patients whilst reducing the onward transmission of HIV. (p. 736)

Neuropsychological Assessment
In an effort to form and validate a **screening battery** for purposes of detecting HIV-related neuropsychological (NP) impairment, Carey et al. (2004b) compared the diagnostic accuracy of 14 paired combinations of six NP measures drawn from a larger NP battery administered to 190 people living with HIV. Performance was considered

NP impaired if demographically corrected *T*-scores fell below 40 on both tests, or below 35 on one test. ... The most sensitive test combinations were the Hopkins

fidentiality and decisions regarding treatment, ... stigma associated with the disease, ... and inadequate support. ... Coping with ongoing loss was a primary stressor for HIV/AIDS health care workers. ... They constantly had to witness patients endure pain, disability, and death. ... Watching while young people died in the prime of life imposed a heavy emotional burden. (Demmer, 2004, p. 528)

While a number of these stressors continue in the HAART era (e.g., work overload; contentious relationships with colleagues, supervisors, and administrators; paperwork demands; low levels of monetary compensation in AIDS service organizations; HIV stigma), new stressors have emerged in the context of improved treatment. According to Demmer, these include:

o **Uncertainty** – Just as people living with HIV struggle to balance optimism regarding the benefits of HAART with the management of side effects and questions regarding HAART's long-

term efficacy, so too do their providers.

o **Shift from "hero" to provider of routine care** – While clinicians in the pre-HAART era developed intense relationships with clients and concentrated their efforts on providing physical and emotional comfort to those who were preparing to die, HIV care today may be experienced as less "interesting" and/or exert less of a pull for personal involvement on the part of providers.

o **Antiretroviral adherence issues** – If death was the central focus of care in the pre-HAART era, adherence has assumed preeminence with the emergence of concerns about the development of antiretroviral resistance.

o **Resumption of risky sexual behaviors among clients** – Improved health and the perception among some that HAART has made HIV less of a threat have intensified the need to focus on secondary HIV prevention (i.e., "prevention for positives") in the context of clinical care.

o **Death of clients** – Although people are living longer with HIV, deaths continue to occur from AIDS-defining conditions, challenging newer clinicians, who may feel unprepared for a client's death, as well as veteran providers, for whom recent deaths may tap into unresolved grief from the pre-HAART era.

<u>Upping the Ante</u>
Mental health professionals offering HIV-related psychotherapy must contend not only with the stresses inherent in HIV care, but also the stresses particular to the work of the psychotherapist. "While psychotherapy can be rewarding, it is often demanding and lonely, filled with excessive expectations and a lack of gratification. This can obviously lead to stress and subsequent burnout. Dealing with the emotional suffering of others, both patients and families, also has its effects on the psychotherapist. This leads to 'compassion-fatigue', depletion of emotional resources and subsequent burnout" (Rabin, Feldman, & Kaplan, 1999, p. 163).

Verbal Learning Test - Revised (HVLT-R; Total Recall) and the <u>Grooved Pegboard Test nondominant hand</u> (PND) pair and the HVLT-R and <u>WAIS-III Digit Symbol</u> (DS) <u>subtest</u> pair (sensitivity = 78% and 75%, respectively). Both test combinations (HVLT-R/PND, HVLT-R/DS) were more accurate than the HIV Dementia Scale (HDS) in classifying HIV+ participants as NP impaired or unimpaired. (p. 234)

Carey and colleagues "suggest that <u>demographically corrected *T*-scores from pairs of common NP measures may serve as valid screening instruments to identify subjects with HIV-related neurocognitive impairment who could benefit from more extensive NP examination</u>" (p. 234).

In another study, Carey et al. (2004a) administered comprehensive NP test batteries to 88 HIV-positive individuals and 61 matched

HIV-negative controls and converted demographically corrected test data to a **Global Deficit Score** (GDS). The GDS is a summary score that "simulates clinicians' ratings by quantifying the number and degree of impaired performances throughout the test battery while attaching relatively less significance to superior performances and/or those within normal limits" (p. 307). They found that "the GDS discriminated between the HIV+ and HIV- groups such that the HIV+ sample's mean GDS was significantly higher (indicating poorer performance) than the HIV- sample. In fact, when examining the magnitude of between-group differences in performance, the GDS showed a larger effect size ... than any individual NP test ... . At a cutpoint of ≥ 0.50, the ... clinician can be increasingly confident that HIV+ participants rather than healthy controls produced GDS scores in this range" (p. 314). Carey and colleagues conclude that the GDS is a clinically useful method

of summarizing NP testing results, as their study

demonstrated <u>the strong predictive power of the GDS method in classifying HIV group membership and HIV-associated NP impairment</u>. The current findings also suggest that the GDS approach is generalizable to different NP test batteries comprised of demographically corrected measures that cover the same cognitive ability areas. By reporting several indices of diagnostic usefulness across a number of different cutpoints, we provided detailed information regarding the predictive validity of the GDS. Based on the approach's robust diagnostic efficiency across different samples and test batteries, coupled with its apparent ability to reduce both Type I [false positive] and Type II [false negative] error, we recommend the GDS approach

Seven Salutary Suggestions

Interventions to reduce workplace stress and prevent burnout are generally pitched at the systems (organizational) level and/or the level of the individual mental health practitioner.

With regard to the latter, Osborn (2004) offers a novel perspective by shifting "from a problem, deficit, and pathology focus (i.e., 'burnout prevention') to a growth, mastery, and salutary orientation (i.e., 'stamina promotion') ..." (p. 321) in framing interventions initiated by and for the care of the individual mental health provider. This health-oriented perspective on professional longevity centers on helping the clinician to maintain stamina in the work.

What does she mean by stamina? "A discussion of stamina [draws] attention to the cultivation, amplification, and routine use of one's strengths and resources, as opposed to focusing on a problem (i.e., burnout) and outlining attempts to rid oneself of or continually fight against the problem (i.e., coping) ... [and so shifts] attention away from notions of stress and depletion. It focuses instead on cultivating resources intended to keep one's outlook positive and one's work fresh, relevant, and rewarding" (p. 319).

Osborn presents seven components of stamina that take the form of a mnemonic, with each component corresponding to one of the seven letters in the word STAMINA. While not exhaustive, her listing includes:

o **S**electivity – "Selectivity refers to the practice of intentional choice and focus in daily activities and long-term endeavors. It means setting limits on what one can and cannot do and, in the process, being deliberate in one's tasks and purposeful in one's mission" (p. 322). In practice, selectivity involves the development of reasonable appointment schedules and realistic, individualized treatment plans. It also involves projecting a clear professional identity with regard to therapeutic posture, the scope of practice, and areas of professional expertise.

o **T**emporal Sensitivity – Mental health professionals "must be constantly aware of the given restrictions and limitations of time – in sessions with clients, in determining the appropriate length of overall treatment, and in the spacing of sessions – and make the best use of the time allotted" (p. 322). "[T]emporal sensitivity implies that time is not only something to be managed or manipulated well (e.g., working within deadlines, arriving to and ending ... sessions 'on time'), but also something that is viewed realistically and respectfully" (p. 322). Osborn suggests that "[a]cknowledging the limitations of time fosters an appreciation for and a focus on the present moment, which may imply effective and meaningful ... practice" (p. 323).

o **A**ccountability – "[A]ccountability ... refers in part to being able to practice according to a justifiable, ethical, theoretically guided, and research-informed defense – one that has merit and makes sense not only to ... clients or the [clinician] him- or herself, but also to the group of professionals of which the [clinician] is a part. ... [A]ccountability – and credibility – refers to respecting and working within professional guidelines (e.g., standards of care ...) [and] generates stamina when the [clinician] takes responsibility for ... his or her clinical decisions and actions. This [reflects] an internal locus of control, which [has been] found [to be] related to higher job satisfaction, ... less burnout, and less perceived conflict on the job among social workers and case managers" (p. 323). Accountability is evident when a clinician invites feedback about his or her clinical work, participates actively in professional associations and continuing education opportunities, and keeps tabs on the professional research literature, since accountability "involves openness to innovation and a consideration of multiple perspectives" (p. 323).

o **M**easurement and Management – "[T]his ingredient of ... stamina stipulates that the [clinician] makes conscientious, careful and ongoing efforts to conserve and protect those resources he or she values" (pp. 323-324). Included in these resources are time, material possessions (e.g., books), conditions (e.g., rewarding work, ethical boundaries), personal characteristics (e.g., thoughtfulness, hopefulness, assertiveness), and energies (both monetary and intellectual). "[P]sychological stress occurs when these resources are threatened or lost, or when investments are made that do not reap the anticipated level of return. The result may be analogous to emotional exhaustion, one of the three dimensions of burnout ... . Protecting and conserving the resources of one's energy, time, and compassion, for example, may therefore attenuate psychological stress, prevent burnout, and contribute to ... stamina" (p. 324). Practically, the cultivation and preservation of resources are facilitated through regular consultation with at least one trusted colleague, bringing supportive people into one's life, and participating in enriching, personally satisfying activities and relationships, which might include the pursuit of one's own psychotherapy.

o **I**nquisitiveness – "Cultivating and sustaining stamina ... involves ... a 'disposition of wonder or curiosity' ... about human behavior and the unique experiences of individuals, a fascination that may have represented the early or initial appeal of becoming a helping professional. Without a posture of intrigue or regard for the therapeutic process as one of 'mutual puzzling' ..., [clinicians] may be vulnerable to burnout" (p. 324). Inquisitive clinicians honor the individuality of each client, consider a diagnosis what one *has* and not who one *is*, and suspend judgment to become a student of the client's experiences. In fact, inquisitiveness fuels stamina when the clinician "assum[es] the posture of a student in all areas of ... practice, continually intrigued by and learning from clients, colleagues, [the] profession, and him- or herself" (p. 325). Such openness is reflected in continual study of developments in psychotherapy, ongoing consultation regarding one's practice, and engagement in a process of self-examination.

o **N**egotiation – "Negotiation ... can be understood as one's ability to be flexible, to engage in give-and-take, without 'giving in.' In addition, clinical and other professional decisions and actions are purposeful (or well grounded); informed by standards of care, theory, and research; and not conducted haphazardly or arbitrarily. Understood in another way, [clinicians]

need to be responsive to and cooperate with others, while simultaneously remaining steadfast to and upholding certain values, guidelines, or standards" (p. 325). "Professional[s] generate and sustain stamina by initiating and participating in processes of negotiation (with people, ideas, policies, etc.), and viewing such interactions as collaborative and coconstructive, rather than viewing themselves solely as passive recipient or 'expert'/'answer bearer'" (p. 326).

o **Acknowledgment of Agency** – In this instance, "agency refers to ... an intangible, dynamic force; the 'life blood' of a person; and the trait or condition whereby instrumentality (or one's purpose) is manifested" (p. 326). By acknowledging agency, clinicians recognize "and make use of the undeniably persistent strength, resourcefulness, and will of the human spirit – within him- or herself and with his or her clients" (p. 326).

Averting Burnout Administratively
Mental health administrators are in an excellent position to facilitate reductions in and management of workplace stress experienced by mental health professionals and contributing to burnout. A variety of approaches, adapted from Rabin, Feldman, and Kaplan and used separately or in combination, are offered below:

o **Identify sources of stress and promote positive coping strategies in individual clinicians** – While administrators are well situated to promote positive coping by intervening at the systemic level (several examples follow), they can also support mental health professionals by promoting personal resourcefulness/self-care skills. These include self-assertion, rational thought and decision-making, open communication and concern for colleagues, use of stress management techniques (e.g., meditation, relaxation methods), and encouragement of effective planning and organization (e.g., goal setting, time management, etc.).

o **Peer supervision or peer consultation groups** – These are leaderless groups in which mental health professionals meet on a regular basis to review cases and contemplate approaches to treatment. Members share their knowledge and expertise, collaborate with colleagues, and contribute to the professional development of their fellow clinicians.

o **Balint groups** – "Balint groups have an open and supportive style but are similar to peer supervision in their openness and are run by two group leaders. These groups provide health providers with a sympathetic and accepting forum to present instances of work-related interactions troubling them at a given moment. … Balint group experiences have been found to enhance professional self-worth, self-esteem, and confidence … . Primary care health providers (doctors, nurses, social workers) have benefited much from these experiences and recently these groups have been found to be effective in reducing and preventing burnout. … Integrated groups of mental and primary care providers have also been found to help the two groups collaborate more effectively" (p. 164).[1]

o **Support groups** – These include:

o system-oriented, work-based groups composed of members from the same functional unit (e.g., a multidisciplinary treatment team);
o long-term groups composed of members with the same or related training who work in different agencies or facilities; and
o short-term groups composed of members who meet for a certain number of sessions to address a specific issue (e.g., employee victims of violence in a healthcare facility).

"The underlying focus of all these support groups should be to enhance the mental health providers' perceptions of the importance of collegial support, which has been found to diminish the level of depersonalization often experienced by staff members ..." (p. 164).

o **Modifying organizational factors** – "Examples are improving ... working conditions and optimizing work sched-

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[1] For more information, see "'Essential' and 'desirable' characteristics of a Balint group," approved by the Council of the British Balint Society, March 1994: http://familymed. musc.edu/balint/Balintgroups.html.

ules for the benefit of ... employees, including providing a mentoring system for new professionals ..., changing the function of staff meetings into a more supportive/caring mode, and encouraging achievement of the staff. ... Social events (get-together evenings, team field trips) may also ... reduce team burnout" (pp. 164-165).

o **In-service training programs** – "Chronic stress and subsequent burnout can be considered a breakdown in ... a person's feelings of efficacy ... . This feeling of efficacy may be restored by their gaining greater knowledge and clinical experience as a way of reducing perceived vulnerability to the stressors of therapeutic work ..." (p. 165).

o **Clinical supervision** – Clinician "overinvolvement" with a client can lead to emotional exhaustion. Supervision can assist in identifying and addressing overinvolvement, with a goal of re-establishing appropriate boundaries.

o **Temporary withdrawal from clinical work** – "In some instances, temporary withdraw[al] ... may be a practical way of coping with burnout. Planned temporary withdrawal can quell feelings of emotional overload through physical withdrawals (e.g. reduction of contact hours with patients, work breaks or absences, vacations); psychological withdrawal (e.g. cognitive coping with ... distracting thoughts); and shifting to work tasks which do not involve direct contact with people ... . An innovative practical solution for burnout is the 'decompression routine' between leaving work and coming home. Mental health professionals can engage in some solitary activity in order to unwind, relax and take their mind off the events of the day ..." (p. 165).

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as a valid and useful adjunct to statistically examining group mean differences. Our findings indicate that a GDS cutpoint of > 0.50 provided an optimal balance between sensitivity and specificity in the HIV+ sample ... . (p. 316)

HIV Treatment News

Psychiatric/Psychological/ Psychosocial/Spiritual Care

Neuropsychological Impairment
Baldewicz et al. (2004) evaluated attention, executive functioning, fine motor speed, speed of information processing, and verbal memory at 6-month intervals *over an 8-year period* in two cohorts of well-educated gay men – 59 HIV-positive (and clinically asymptomatic at baseline) and 55 HIV-negative – and

found deficits in specific areas of [NP] functioning with HIV-1 disease progression over time, specifically in the domains of fine motor speed and speed of information processing. As predicted, these findings were particularly prominent in patients meeting either the clinical and/ or immunological criteria for AIDS-defining illness. ... This 8-year study extends the existing longitudinal literature and is consistent with the meta-analysis conducted by Reger *et al.* (2002) on the data in the [NP] literature showing that **cognitive decline worsens with HIV-1 progression**.[1] (p. 352)

[1] Summarizing 15 years of research on the NP sequelae of HIV infection (i.e., 41 primary studies involving an aggregate of 8,616 participants and covering 10 major NP domains, with effect sizes calculated to ascertain between-group [asymptomatic, symptomatic HIV-positive, AIDS] differences in each domain), Reger, Welsh, Razani, Martin, and Boone (2002) offer the following observations:

1. Compared to seronegative controls, HIV+ patients exhibit relative cognitive deficits that are small in magnitude at the

Notably, "[p]erformance was further slowed by the presence of depressive symptomatology" (p. 353). "Depressive symptoms were associated with diminished performance on measures of attention, executive functioning, and speed of information processing suggesting that patients with greater depressive symptoms may have had poorer abilities to concentrate in general, and that this affected their performance on the more complex tasks" (p. 352).

Access to Care
To identify barriers to accessing **smoking cessation services** and techniques for surmounting them, Lazev, Vidrine, Arduino, and Gritz (2004) conducted two pilot studies. In the first, a low-income, multiethnic sample of 49 people receiving HIV primary care services reported that, while they were interested in such services, their capacity to participate was limited by transportation difficulties, transience, and inconsistent access to a telephone. In response, a smoking cessation intervention, consisting of six telephone counseling sessions over a 2-week period, was conducted with 20 individuals from this population who were provided with free cellular phones. Nineteen of the 20 participants completed the program, with a contact rate of 93% (106 of the 114 counseling calls that were made) and the abstinence rate two weeks follow-

asymptomatic stage and that increase with disease progression. [Motor functioning, executive skills, and information processing speed were among the domains showing the greatest decline from early to later stages of HIV disease.]

2. Domain-specific cognitive decline was detected and deficits resembled a "subcortical" pattern.

3. Although a subgroup of HIV+ asymptomatic patients with conventionally defined [NP] deficits may evidence functional and occupational dysfunction, overall the deficits documented in our meta-analytic study should not affect vocational performance in this group of HIV-infected individuals. (p. 417)

ing the quit date was 75%. "The provision of cellular telephones allowed for the implementation of a proactive telephone smoking cessation intervention providing an underserved population with access to care. Cellular telephones also may provide unique benefits because of the intensity of counseling and support provided as well as the ability to provide counseling in real-world, real-time situations (in vivo counseling)" (p. 281).

Adherence to Treatment
In comparing three **self-report antiretroviral adherence tools**, Wiener, Riekert, Ryder, and Wood (2004) found little agreement across measures. These measures included a clinical nurse rating, a retrospective self-report interview, and a 24-hour recall phone interview; all were used with a sample of 35 adolescents between the ages of 11 and 21 who were engaged in an HIV clinical trial. The authors observed that "[g]enerally, when … adolescent[s say] they are nonadherent, they are being truthful[, but w]hen they say they are being adherent, they may or may not be taking their medications as prescribed" (p. 535). Wiener and colleagues go on to highlight several clinical implications of these findings:

First, it is important to assess adherence during every medical appointment and to determine if the nonadherence is to a particular drug versus overall [antiretroviral] nonadherence ... . A simple question of whether or not a dose was missed in the past week may be sufficient. Second, clinicians should ask ... specific questions about medication use and calculate adherence scores rather than rely solely on clinical markers or health care provider impressions. ... The ability to get an accurate sense of medication adherence with self-report mea-

sures may be possible when combined with honesty, respect, providing the adolescent time to talk privately, framing the medication side effects in the context of the potential benefits, assessing social support and motivation to be well, and most of all, the ability of the health care provider to truly listen to their concerns ... . Most importantly, obtaining a report of nonadherence should not be followed by punitive, disappointed, or scolding statements. Rather, learning of nonadherence should be used as a stepping-stone to addressing barriers in a supportive manner and an opportunity to introduce new problem solving skills. Connecting teens to other teens who share similar challenges with adherence can decrease their sense of isolation and increase their willingness to have hope in the face of a disease where life sustaining treatments are available but still no cure exists. (p. 535)

In a similarly supportive vein, Kennedy, Goggin, and Nollen (2004) investigated the utility of **self-determination theory** (SDT)[2] in predicting antiretroviral adherence in a convenience sample of 205 adults recruited from four HIV clin-

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[2] "SDT centers around the role of autonomous motivation, ... which opposes the perception of undue pressure and obedience to medical authority. ... [T]reatment decisions and associated behaviors are viewed as falling within the patient's domain. Individuals who regulate their behavior autonomously choose to do so because of the personal importance of the behavior for their health ... . According to SDT ..., autonomous motivation is predicted by autonomy support, or perceived support from others for making autonomous decisions with regard to a particular health behavior ... . SDT also suggests that the relationship between autonomous motivation and the behavior of interest ... is mediated by perceived competence for the behavior. This construct, likened to self-efficacy, is defined ... as an individual's confidence in his or her ability to carry out the behavior" (Kennedy, Goggins, & Nollen, 2004, p. 614).

ics. Although the model explained only 12% of the variance in adherence, "autonomy support was predictive of autonomous motivation for adherence, which predicted perceived competence for adherence, and ultimately, resulted in greater adherence. Adherence to HIV medication was also associated with low psychological distress" (p. 622). Turning to intervention, Kennedy and colleagues suggest that "[h]ealth care providers who recognize and reinforce autonomy rather than viewing it as a threat can foster a supportive and collaborative environment, improving the odds of effective disease management. Providers should be alert to factors that may interfere with adherence, including psychological distress or a passive approach towards treatment. ... Family education may also help to support patient autonomy and improve adherence rates" (p. 624).

Should adherence interventions vary by **gender**? Berg et al. (2004) checked in monthly with a sample of 113 current and former opioid users (64% male, 43% female) on antiretrovirals and receiving services through a methadone maintenance program and found median adherence (as measured by Medication Event Monitoring System [MEMS] caps) was 27% lower among women (46%) in comparison with men (73%). Moreover, they found that "different social and behavioral factors are associated with adherence in men and women. Among both men and women, worse adherence was associated with lack of long-term housing, not belonging to an HIV support group, crack/cocaine use, and medication side effects. Among women only, alcohol use was associated with worse adherence" (p. 1111). Importantly, when the genders were examined separately,

worse adherence for women

was associated with problem alcohol use and active heroin use. In contrast, for men, not belonging to an HIV support group and active crack or cocaine use were associated with worse adherence. In both men and women, there was an independent association between significant medication side effects and worse adherence. The disparity in these models suggests that the complex behavioral processes that determine adherence and drug use in women may be different than that in men. ... If consistent gender differences are found in future studies, it will suggest that adherence-improving interventions should be gender specific. (pp. 1114-1115)

Serostatus Disclosure
Parsons, VanOra, Missildine, Purcell, and Gómez (2004) interviewed a racially- and ethnically diverse convenience sample of 158 HIV-positive, primarily **heterosexual IDUs** in the New York and San Francisco metropolitan areas and found that

disclosure decisions were motivated largely by three central themes: fears of negative consequences, the potential for positive rewards, and issues of responsibility. Among those participants describing potential negative consequences, many declared that disclosure would invariably lead to stigmatization and rejection from sexual partners. Other negative consequences ... included a variety of threats to one's well-being (including violence) and the potential loss of income and drugs. In addition, a number of participants discussed the potential for experiencing positive consequences resulting from disclosure. These participants described the support, connections, and benefits to their self-

concept associated with positive disclosure experiences and implied that these benefits have the potential to safeguard oneself from the negative risks of disclosing. (p. 471)

Feelings of responsibility affected disclosure and/or sexual behavior in different ways. "For some ... the desire to protect one's sexual partners from potential HIV infection ... motivated disclosure and perhaps overrode ... concerns with negative consequences. Other[s] disclosed so as to extricate themselves from the responsibility of ensuring safer sexual behaviors. ... Some ... asserted that they owned the responsibility for ensuring safer sexual behaviors but not for disclosing. In other words, [they] believed that disclosure was not necessary because they always insisted on condom use" (pp. 471-472).

Drawing on these findings, Parsons and colleagues suggest that clinicians working with HIV-positive IDUs on the issue of disclosure

[highlight] instances in which disclosure was not responded to negatively but instead allowed HIV-positive individuals to develop deeper and more intimate connections with their sexual partners. [I]nterventions … should [also] emphasize gaining the support and resources (independent of … sex partners) that would serve as buffers against the extreme social, emotional, and physical consequences of disclosing one's positive serostatus. This might be key to reducing the severity of the negative consequences moderating disclosure ... thus facilitating disclosure ... . In addition, ... interventions should acknowledge the varied patterns of the relationship between disclosure and sexual risk behaviors and might instead focus on

increasing perceived responsibility to protect partners from HIV infection, with or without disclosure. (p. 473)

Using both qualitative and quantitative methods in a second study involving this sample, Parsons et al. (2004) found that more study participants disclosed to sex partners who were also HIV-positive than to partners who were negative or of unknown serostatus. Surprisingly, more disclosed to casual than to main sex partners before their first sexual encounter. Those who disclosed consistently reported more unprotected sex (particularly when engaging in vaginal sex) than did nondisclosers; they were also more likely to believe that they had a duty to disclose. Those who did not disclose were less likely to believe that they had a duty to disclose and reported greater resentment about wearing condoms. The most "emotionally upsetting" narratives were offered by those who disclosed to a main partner *after* their first sexual encounter ("eventual disclosers"). The authors speculate that

disclosure may be more likely to occur with partners in a reduced anxiety situation, making [disclosure] more likely [with] a casual partner over a main partner before first sexual contact. ... Preliminarily, it seems that participants were least likely to disclose to those partners for whom emotional investment was either very high or very low. Thus anxiety around disclosure and the fear of being rejected based on serostatus may contribute to differential disclosure behavior based on partner type. However further studies are needed to explore this trend. (p. 467)

Of particular concern was the finding that nondisclosers *did not see it as their responsibility* to disclose to sexual partners of negative or un-

known serostatus if they were not also sharing needles with them. This finding suggests that those "who work [with] needle sharing

Tool Box
Resources

Books & Articles:
Avants, S.K., & Margolin, A. (2004). Development of spiritual self-schema (3-S) therapy for the treatment of addictive and HIV risk behavior: A convergence of cognitive and Buddhist psychology. *Journal of Psychotherapy Integration, 14*(3), 253-289.
"3-S therapy ... integrates contemporary cognitive-behavioral techniques with a spiritual path, here using a Buddhist framework, that can readily be adapted to incorporate individual religious beliefs and practices and that can target addictive and HIV risk behavior in the treatment of clients suffering from addiction" (p. 282).

Barroso, J., & Sandelowski, M. (2004). Substance abuse in HIV-positive women. *Journal of the Association of Nurses in AIDS Care, 15*(5), 48-59.
"In this article, we report the results of a qualitative metasynthesis of studies containing information on substance abuse among HIV-positive women, using 74 published and unpublished reports. The data on 1,548 women, who were primarily mothers from minority groups, allowed us to construct a trajectory that describes the events of their lives with regard to substance abuse and its intersection with HIV infection" (p. 48).

DeFino, M., Clark, J., Mogyoros, D., & Shuter, J. (2004). Predictors of virologic success in patients completing a structured antiretroviral adherence program. *Journal of the Association of Nurses in AIDS Care, 15*(5), 60-67.
"This study describes the [beneficial] effects of a structured, educational/ motivational antiretroviral adherence program on virologic and immunologic parameters in HIV-infected patients. Patients were referred because of either self- or provider-identified barriers to adherence. All patients completed 6 to 8 weekly sessions with a nurse or adherence counselor, followed by four quarterly sessions. Sessions included an adherence assess-

populations ... should <u>emphasize the importance of disclosure to all partners, regardless of whether it is sharing needles or having sex or</u> both" (p. 468).

<u>Care for Caregivers</u>
Land and Hudson (2004) surveyed 432 AIDS caregivers – 192 Anglo gay/bisexual men, 86 Anglo women, and 154 Latinas (largely of Mexican descent) – and found that, while all

ment, individualized patient education, review of adherence strategies, motivational messages, anticipatory planning, and adherence tools" (p. 60).

Dickson-Gómez, J.B., Knowlton, A., & Latkin, C. (2004). Values and identity: The meaning of work for injection drug users involved in volunteer HIV prevention outreach. *Substance Use & Misuse, 39*(8), 1259-1286.
"Most HIV behavioral interventions provide ... preventive information emphasizing how not to behave, and have neglected to provide attractive and feasible alternatives to risky behavior. Interventions that emphasize cultural strengths may have more powerful effects and may help remove the stigma of HIV, which has hampered prevention efforts among African American communities. Starting in 1997, the SHIELD (Self-Help in Eliminating Life-Threatening Diseases) intervention trained injection drug users ... to conduct risk reduction outreach education among their peers. Many participants saw their outreach as 'work,' which gave them a sense of meaning and purpose and motivated them to make other positive changes in their lives" (pp. 1259-1260).

Ferri, R.S. (Ed.). (2004). Symptom management in the age of highly active antiretroviral therapy. *Journal of the Association of Nurses in AIDS Care, 15*(5 Suppl.), 5S-33S.
This supplement to the September/October 2004 issue addresses "clinical and psychosocial sequelae affecting quality of life, management of common symptoms affecting quality of life, and the tools to measure quality of life in HIV-infected individuals" (pp. 5S-6S).

Fulk, L.J., Kane, B.E., Phillips, K.D., Bopp, C.M., & Hand, G.A. (2004). Depression in HIV-infected patients: Allopathic, complementary, and alternative treatments. *Journal of Psychosomatic Research, 57*(4), 339-351.
"The purpose of this review article is to synthesize the current knowledge related to depression and HIV disease" (p. 339).

Gordon, C.M., Stall, R., & Cheever, L. (Eds.) (2004). Prevention interventions with persons living with HIV/AIDS. *Journal of Acquired Immune Deficiency Syndromes, 37*(Suppl. 2), S53-S141.
"This supplement was initiated after a meeting sponsored by the Center for Mental Health Research on AIDS (National Institute of Mental Health [NIMH]) and the Centers for Disease Control and Prevention (CDC) held in conjunction with the 2003 National HIV Prevention Conference in Atlanta. The goal was to discuss state-of-the-science behavioral risk reduction with HIV-positive persons and to outline immediate research needs" (p. S53).

Leszcz, M., Sherman, A., Mosier, J., Burlingame, G.M., Cleary, T., Ulman, K.H., Simonton, S., Latif, U., Strauss, B., & Hazelton, L. (2004). Group interventions for patients with cancer and HIV disease: Part IV. Clinical and policy recommendations. *International Journal of Group Psychotherapy, 54*(4), 539-556.
"Earlier sections of this Special Report examined empirical findings for these interventions and provided recommendations for future research. The current section offers brief recommendations for service providers, policymakers, and stakeholders" (p. 540).

Pantin, H., Schwartz, S.J., Sullivan, S., Prado, G., & Szapocznik, J. (2004). Ecodevelopmental HIV prevention programs for Hispanic adolescents. *American Journal of Orthopsychiatry, 74*(4), 545-558.
Pantin and colleagues "illustrate how an ecodevelopmental perspective on risk and protection can be applied to the study and prevention of unsafe sexual behavior in Hispanic immigrant adolescents" (p. 545).

Poehlmann, J., White, T., & Bjerke, K. (2004). Integrating HIV risk reduction into family programs for women offenders: A family relationship perspective. *Family Relations, 53*(1), 26-37.
The authors illustrate ways in which family programs targeting women offenders can incorporate HIV risk reduc-

tion interventions.

Smiley, A. (2004). The intrapsychic realm of HIV/AIDS and related homelessness: Two case studies. *Clinical Social Work Journal, 32*(3), 251-269.
"The experience of clients with HIV/AIDS and related homelessness (as well as substance abuse) is explored intrapsychically ... . Concepts involving the early anxiety-situation, containment and holding inform two pertinent case studies and illuminate effective psychotherapeutic approaches to working with this population" (p. 251).

Stoff, D.M., Mitnick, L., & Kalichman, S. (Eds.). (2004). Research issues in the multiple diagnoses of HIV/AIDS, mental illness and substance abuse. *AIDS Care, 16*(Suppl. 1), S1-S153.
"This supplement ... contains a series of conceptual and methodologically based papers that emerged from the multisite research study, the HIV/AIDS Treatment Adherence, Health Outcomes and Cost Study ..., to investigate the efficacy of integrated interventions for HIV primary care, mental health and substance abuse on adherence, health outcomes and costs. Although these papers cover a wide range of topics related to people living with HIV infection who also have a diagnosed mental health and substance abuse disorder ..., they all coalesce around common themes that focus on HIV disease as a chronic illness, the impact of neuropsychiatric and substance use co-morbidities on HIV disease and the development of integrated interventions for comprehensive HIV care" (p. S1).

<u>Internet Resources</u>:
The 7th International AIDS Impact Conference will convene April 4-7, 2005, in Cape Town, South Africa. Since 1991, this conference "has addressed the changing interaction between the biological, psychological and social effects of HIV infection." For more information, go to: http://www.aids impact.net/.

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groups displayed moderate levels of depression, predictors and mediators of depression varied across groups. Depression in Latina caregivers, for example, was more highly influenced by background factors (e.g., younger age, lower socioeconomic status, poorer physical health in the caregiver) than was the case for Anglo caregivers – regardless of gender. Among gay/bisexual male caregivers, depression was more highly influenced by objective stressors (e.g., assisting with activities of daily living [ADLs]) than was the case for female caregivers – regardless of ethnicity. These **gender and cultural perspectives**, in turn, influence how caregivers view and access external resources to assist with caregiving. Depression in male caregivers, for example, might be addressed by facilitating access to direct caregiving services (e.g., in-home attendant care, adult day care), while depression in Latina caregivers might be addressed through the provision of health care services for the caregiver herself. Clinicians also need to work "to reduce those stressors that are more influenced by the cognitive and psychological processes of the caregiver such as feelings of overload, captivity, loss of self to the caregiving role, and low self-esteem" (p. 663); Land and Hudson found that "self-identity and related esteem may have a powerful effect on depression and should be addressed in [the] provision of mental health [services] for all caregivers" (p. 662).

Coping, Social Support, & Quality of Life

Prado et al. (2004) interviewed 252 low-income, inner-city African-American mothers living with HIV and found that "(a) **religious involvement** was directly related to higher levels of active coping and to lower levels of avoidant coping; (b) religious involvement was related to higher levels of social sup-

port, which in turn was related to higher levels of active coping and to lower levels of avoidant coping; and (c) active and avoidant coping styles were negatively and positively related to psychological distress, respectively" (p. 231). The authors reason that "interventions to attenuate psychological distress in HIV-seropositive African American mothers might focus on promoting active coping and decreasing avoidant coping. ... [F]indings suggest that this may be accomplished, in part, by promoting involvement in religious institutions and practices (which in turn may increase social support as well)" (p. 233). They are, however, quick to point out that "religion may have both positive and negative consequences ..., and given the cross-sectional design used in the present study, further research is needed to determine the extent to which promoting religiosity may increase or alleviate distress" (p. 233).

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Tool Box
A Note on Content

This publication has been developed to help the frontline provider of HIV-related mental health services, allied professionals, and consumers stay up-to-date on research-based developments in HIV care. The contents for the "Biopsychosocial Update" are drawn from a variety of sources including, but not limited to: the *CDC HIV/ STD/TB Prevention News Update* (http://www.cdcnpin.org/news/ prevnews.htm); the *Kaiser Daily HIV/ AIDS Report* (http://report.kff.org/ hivaids/); and information e-mailed by Florida International University researcher Robert M. Malow, Ph.D., ABPP. Other sources are identified when appropriate.

It is presumed that readers have at least a fundamental understanding of medical, psychiatric, psychological, psychosocial, and spiritual considerations when assessing and intervening with people who are living with HIV/ AIDS and their families. For additional background information on these aspects of care, the following resources may be of assistance:

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Shernoff, M. (Ed.). (2000). *AIDS and mental health practice: Clinical and policy issues.* Binghamton, NY: Haworth Press.

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